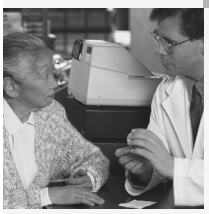
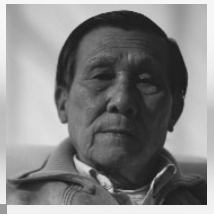





National Medical Association

Cultural Competence Primer



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Introduction

The National Medical Association (NMA) is the oldest and largest national professional medical association representing over 25,000 African American physicians. Established in 1895, the NMA is the collective voice of African American physicians and the patients they serve, since its inception, the NMA has been committed to improving the health status and outcomes of minority and disadvantaged people. Although, throughout its history the NMA has focused primarily on health issues related to African Americans and medically underserved populations, its principles, goals, initiatives and philosophy encompass all sectors of the population. The NMA is committed to improving the health status and outcomes of all Americans. More than 100 years later, the National Medical Association has become firmly established in its rightful leadership role in medicine.

The membership of the NMA represents predominantly African American physicians, but is open to all physicians that share their mission and objectives. The membership comprises physicians in the primary care specialties, as well as all other medical and surgical subspecialties, academic medicine, military medicine and medical administration. The association's membership data supports the markedly high number of patients served by member physicians are poor, uninsured, underinsured, and/or beneficiaries of Medicaid or Medicare, when compared to majority physicians. To this end, the NMA has unique and legitimate insight into the plight of the underserved patient and as part of the core mission must continue to serve as a catalyst for the elimination of disparities in health and the leading force for parity in medicine.

Despite the miraculous progress of modern medicine, a large proportion of minority populations continue to experience an unequal burden of poor health conditions and outcomes. African Americans are affected disproportionately on virtually every reported health index. Forty–four percent more African Americans, vs. the general population, die from cancer each year and 30 percent more from heart disease. Thirty–five percent of African American men suffer from hypertension, compared to a national average of 25 percent. Diabetes is more than 80 percent higher among African Americans than the general population. The impact of HIV/AIDS, violence, substance abuse, unintentional injuries, vaccine preventable diseases, infant mortality and many other preventable conditions are well documented and severely affect the quality of life for African Americans in the United States. To this end, the overall state of African American health constitutes a continued national health care crisis.

Although the reasons for disparate African American health are numerous and complex, we know they include differences in access to health care services, cultural behavior and beliefs, and limited access to clinical trials research. In accordance with its purpose, the NMA has upheld its priority of developing strategies to facilitate improvements in health care for African Americans through policy initiatives, special programming, training opportunities, and collaborative partnerships. Recognizing the need to augment policy initiatives and public awareness strategies with tangible provider oriented activities served as the impetus for the NMA's governing body to launch the development of a training design in cultural competence for physicians and other health care providers.

Introduction

Cultural competence has increasingly become a central theme for discussion and investigation not only in medicine but also in other health and social service professions. As the nation's only organization devoted to the needs of African American physicians, health professionals, and their patients, the NMA is in a pivotal position to propose and advocate for solutions. The NMA's Cultural Competence Primer will focus on the following objectives:

Main Objectives of the Primer

- Provide a basic definition of Cultural Competence
- Introduce Cultural Competence's impact and the applications to health services delivery
- Create awareness of the need for incorporation of cultural competence into clinical practice and into medical education

The Need for

Cultural Competence in Health Care

The NMA's focus on cultural competence reflects its mission, historical commitment to improve health outcomes for people of color, and its ongoing programmatic thrusts to achieve parity in healthcare. Cultural competence has increasingly become a central theme for discussion and investigation not only in medicine but also in other arenas. Through awareness building efforts cultural competence is finding its way onto the agendas of policy-makers, accrediting and licensing bodies, professional organizations, and in university curricula. A wide spread absence of cultural awareness and competence exists among health care professionals in providing care for a large segment of ethnic and cultural minorities in the United States. This lack of awareness or attention exists on all levels of our health care system, which includes professionals, staff, institutions and allied industries.

After numerous medical literature articles suggested racial bias in medicine as an unmeasured and not well understood contributor to disparities in health care, the NMA convened a consensus panel to explore the issue in greater detail. During 2000 the NMA released the consensus paper, "Racism in Medicine and Health Parity for African Americans" and expressed these serious concerns to congressional legislators. As a direct result, Congress approved a study to be undertaken by the Institute of Medicine (IOM) on ethnic health disparities and the influence of racism.

This study "Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care" funded ($800,000) through the Office of Minority Health, further documented what the NMA has published since 1906 in the Journal of the National Medical Association and reemphasizes the NMA's position that disparities in health care for people of color, should not solely be attributed to economics. The NMA considers disparities are a result of the lack of culturally relevant health care treatment and medical information not standardized for the nations fastest-growing ethnic and cultural populations. The Institute of Medicine's report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care provides unquestionable data that illuminates the need for understanding cultural variations by health care providers. In fact, among the Institute's proposals for eliminating disparities is Recommendation 6-1, which states:

"Integrate cross-cultural education into the training of all current and future health professionals". Health status indicators such as morbidity and mortality rates, infant mortality rates, Cultural Competence: Cultural Competence in Health Care means that the Physician or professional has mastered the art and science of effective communication with the patient such that there is truly bilateral understanding this in addition to using evidenced based "best practices."

The Changing Face of

America's Demographics

The NMA is keenly aware of the ever-changing demographics of the United States. According to the Census Bureau, " The … proportion of the overall population considered to be "minority" (those persons who are nonwhite and of non-Hispanic origin) would increase from 26.4 percent in 1995 to 47.2 percent in 2050."

A review of the literature revels that during the past two decades, minority populations have shown significant growth rates. According to U.S. Census data:

Between 1980 to 1990

- African Americans increased 26.5 million to 30 million
- Asian Americans/Pacific Islanders increased 3.7 million to 7.2 million
- Hispanics/Latinos increased 15.7 million to 22.3 million
- Native Americans/Alaskan Natives increased 1.5 million to 2 million

The racial and ethnic composition of the U.S. population has continued to diversify over the past decade. Between 1990 and 2000, minorities represented 29 percent of the total U.S. population and racial minorities grew at a rate that was six times that for non-Hispanic whites.

Within these racial and ethnic groups are subsegments of the population that have special needs. Often these subsegments of the population are grouped according to age (e.g., seniors, young and middle aged adults, adolescents, and children one-third of whom are minorities); gender (males, females); sexual preferences (heterosexuals, homosexuals); functional status (e.g., the physically and mentally challenged), and health status (e.g., the chronically ill). Caring for individuals within each group requires a holistic approach that encompasses understanding not only their physical and mental health needs, but also influences on attitudes, behaviors and lifestyles within a cultural context. Knowing what is perceived to be culturally acceptable and unacceptable makes a major step towards a better understanding of risk behaviors, interactions with the health care community, achieving compliance with treatment regimens and other outcome measures. This understanding fosters more desirable health status outcomes, and illuminates the problems associated with poor understanding of relevance to health.

TABLE 1

Inadequate Cultural Competence Results in Poor Health Outcomes

- Unequal health
- Unequal health care
- Unequal health care providers
- Unequal health care financial participation by people of color

What Is

Cultural Competence?

The NMA, as well as other thought leaders, continues to mold an encompassing definition around cultural competence. The NMA's current working definitions are structured on the need for the development and adequate understanding in healthcare centers of cultural knowledge, behaviors, interpersonal and clinical skills that enhance a provider's effectiveness in managing patient care.

Cultural competence indicates an understanding of important differences that exist among various ethnic and cultural groups in our country. Unfortunately, the medical community has not previously focused attention on these ethnic and cultural differences. This lack of attention has an effect on all populations, both in terms of health risks and healthcare costs.

In 2000, the NMA officially embarked on the critical path developing educational services and programs using a multicultural contextual framework. This framework includes institutionalizing culturally competent approaches that are reflected in organizational policies, treatment protocols, patient education, interpretation services, facility décor, education for healthcare professionals, their staff and other personnel that represents the populations served. The focus begins with increasing awareness, exposure and embracing differences within the proper medical context. The NMA considers efforts to increase understanding and accepting diverse cultures and their subsequent belief systems, as well as its relevance in health care will lead to improved health outcomes.

TABLE 2

Key Concepts and Definitions of Cultural Competence

Culture:
- Reflected in everything we learn through the process of socialization.
- Dynamic pattern of learned behavior, values, and beliefs exhibited by a group that shares history and geographic proximity.
- Determines health attitudes, roles and behaviors of providers and patients.

Refers to:
- Beliefs.
- Values – general ideas about what is good, bad, right and wrong.
- Includes symbols and language.

Institutions of Cultural Transmission:
- Family (nuclear and extended)
- Educational system
- Political and economic systems
- Religious systems
- Media
- Symbols

Cultural Awareness. Occurs when a person develops sensitivity and cross-cultural understanding. Awareness as referred to changes within oneself toward others. Cultural awareness must be supplemented with cultural knowledge.

Cultural Knowledge. To become familiar with socioeconomic and demographic characteristics, belief system and health behaviors of the members of another culture.

Ethnic Competence. The development of skills that assist a person to behave in a culturally appropriate way (to meet the expectations and/or behaviors) within a given group.

Cultural Competency (Health). The application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhances a provider's effectiveness in managing patient care.

What Constitutes a "Culture"?

Concepts of identity based on racial markers, ethnicity or culture may be useful when discussing trends among populations. There may be several subgroups and diversity within populations and it is "incompetent" to simply categorize. However, they are a piece of the patient's cultural makeup, but they cannot uniformly predict individual behavior.

- The usefulness of these concepts lies in their ability to increase the clinician's awareness of differences. These differences have a direct impact on the patient's health care, not simply from a social standpoint, but also pharmokinetically, the threshold for considering alternative treatment modalities, but not for limiting options in diagnosis or treatment for an individual patient.
- For instance, we cannot merely rely on any general form of racial profiling—using visible or socially constructed markers, such as skin pigmentation, eye shape, language use, or health beliefs, to accurately identify the presence or absence of polymorphisms in drug-metabolizing.

Cultural factors (i.e. attitudes and beliefs held by ethnic and cultural groups) may affect the effectiveness of or the adherence to behavioral interventions, drug therapies and/ or other treatment methodologies. The caution must be to avoid generalizations but to understand the human individuality. There are some cultural themes shared by all ethnic groups, which serve as a fundamental building block to cultural competence. Although clearly not confined to a particular population, some specific themes may be more characteristic of some cultural groups than others. However, all persons from different ethnic and cultural groups share the universal need to be heard, respected and valued.

The themes can be categorized into the following:

- Trust and respect
- Health beliefs and practices
- Family values

TABLE 3

Key Cultural Concepts

Ethnicity and Culture – refer to combinations of socioeconomic, religious, and political qualities of human groups, including language, diet, attire, religions, customs, beliefs, worldviews, kinship systems, and historical or territorial identity.

Racial Group – A group of people who share socially constructed differences based on visible characteristics or regional linkages.

Health Literacy – The ability of an individual to understand and act on health information and advice.

Specific to Pharmacological Properties That May Vary Based on Race, Gender and Some Cultural Components:

- Extensive Metabolizer – An individual who metabolizes a drug at a normal rate of efficiency.
- Pharmacodynamic Properties – Effect of a drug on the body.
- Pharmacogenetics – The study of genetically determined variations in drug response.
- Pharmacogenomics – The effects of the entire genome (i.e., all of the genes) on drug response.
- Pharmacokinetic Properties – Absorption, distribution, metabolism, excretions of a drug.

The Health Professionals' Role in

Cultural Competence

Diversity in Health Care

While recent reports predict a general over supply of physicians and other health care providers, this is not the case for minority health professionals. In fact, although African Americans comprise 13 percent of the nation's population, they only represent an estimated 3.2 percent of the nation's practicing physicians. This is a critical concern because studies show that African American and other health care professionals are much more likely to serve the most vulnerable populations among us — the poor and the medically underserved. As previously stated, similar race and ethnicity of the health care provider does assure that the patient will receive care in a culturally sensitive manner. However, there is commonality and generally a higher degree of understanding from health care providers with similar backgrounds. The NMA, as well as the Institute of Medicine and others, views the shortage of minority physicians as a barrier to patients' access to quality culturally competent health care services and further jeopardizes the health status of these communities. This problem is further compounded by the fact there is a lack of all physicians with the training, tools and often desire to provide culturally competent care of minority populations.

Inherent to the NMA's mission is an implicit intent and concerted effort to eliminate health disparities among minority populations, and in particular African Americans. Past mainstream education and training efforts to introduce physicians and health care providers to culturally sensitive and competent approaches to care have not been effective. These efforts have lacked the comprehensiveness necessary to realize substantial gains in parity relative to health outcomes, service, access, and cost-effective care for minority populations. Furthermore, previous attempts in understanding cultural relevance and sensitivity have solely based the issue on race and socioeconomic factors.

What Must the Provider Do?

The health care professional must invest the time and effort to gain some basic understanding and familiarity of the ethno-cultural and racial groups expected to be encountered in their practice. While it is impossible to delve into the core of each individual patient, one may assess based on the fundamental demographics of the location or practice. Often health care providers are isolated and only view the patient within the confines of the practice setting. However, simple steps to begin to understand variations among patients must begin with understanding your surroundings and observing conversations in your healthcare setting. The health care provider must be open, unassuming and attempt to glean information both with direct questioning and simple observation.

For instance:

- What is the language being spoken on the streets or even in your lobby area?
- How do patients address your staff? Formal greeting or first name?
- How do patients interact with their family member, if present, while in the office?
- Is there a religious affiliation identified on the patient demographic sheet?
- What social or religious centers are within a 5-mile radius of your office?
- What is the patient's sexual orientation?
- What is the educational level of the patient?
- What is the general diet and are their restrictions that have a basis in culture?

It is important to be familiar with culture in terms of values, social hierarchy, and issues of respect. For physicians knowing the health issues, the spectrum of diseases, any peculiarities of treatment, the dietary habits, lifestyle traits that may impact the health of the patient is the beginning of the development of cultural competence in clinical health care. In some cases with certain cultural subsets of patients a familiarity with their religious or spiritual beliefs is important, however, if a provider never asks about preferences or practices this limits useful information.

Attaining this knowledge must be a part of the training and skill sets reflected in and practiced by the entire clinical and patient support staff for any health care facility. Health care professionals often feel that we are "intruding" into the patient's private live, or worse yet, are not aware of the correlation of the value system with health outcomes. The issues of privacy and maintaining a professional relationship must remain at the forefront of the patient–provider relationship. Further, it is usually the provider and NOT the patient that experience discomfort with questioning about sexual preferences, religious beliefs, value systems, education, etc. … The reluctance of sharing by patients is usually based on previous experiences, discrimination and a general lack of trust in the health care system. It is important that the demeanor and deportment of the professional creates an atmosphere of caring and genuine concern for the well–being of the patient and his or her health.

Clinical Applications

A 76–year–old African–American female comes to your office for a follow up visit for hypertension. She states that she is doing OK but that on Sunday she had a horrible headache and felt weak. You ask if she had taken her medication on Sunday, to which she answers no. You immediately begin to counsel her on the need for her to take daily medications and the dangers of high blood pressure. Further, you remind her that AA have higher rates of complications from hypertension and that her headache was just a warning sign. She nods and tells you that she understands and you complete the visit feeling that you have made an impact.

The patient goes home with a refill of her medications but tells her friend that she will take Tylenol on Sundays before church because she will probably always get a headache. The patient is an usher at her church, her prescription is for a diuretic and if she takes the medication she will have frequent trips to the bathroom. In her religious denomination, walking in and out of church is disrespectful and as an usher she has to stand during the entire 2 to 2$^1/_2$ hour service. The patient was never asked the rationale of why she did not take her medication on Sundays, and she did not feel comfortable discussing her urination with a 39–year–old male physician.

The Trust Factor

The professional must engender trust and be trustworthy. The trust factor is equally important as the provider's credentials and expertise. If a patient does not trust that a provider has their best interest in mind, the patient has no reason to comply with treatment recommendations. Current training institutions do nothing to explore the building of trust and the extraction of crucial secondary personal information. The patient must trust that you really listen to their problem regardless of their level of fluency in communication. This trust is eroded when the provider appears to minimize or dismiss what is being said or expressed.

The most basic levels of care can be adversely affected because of cultural language and other communication barriers. Cultural knowledge and beliefs play a key role in arriving at a diagnosis and subsequent treatment plans that are appropriate. Indigenous systems of health practices, beliefs and or medicines exist across all segments of society and can significantly influence a patients attitudes behaviors and initiation or compliance to therapeutic options.

Cultural competence is clinical competence at its highest level!

Clinical Applications

A 43-year-old male immigrant from Pakistan comes to your office with a complaint of fatigue and weight loss over the last 3 weeks. He has a family history of prostate cancer and states that recently he has not been urinating as frequently. During your examination he is very quiet, gives one-word answers and offers no other symptoms. He has no change in appetite, and in fact has been very hungry during this period. He works as a security guard at night. You proceed with the usual workup, focus on diagnosis and order a series of procedures/tests. The workup is essentially negative, except for ketones in the urine and you await further lab tests, instruct him to take multivitamins and schedule a return visit in 6 weeks. When the patient returns, he has gained 13 pounds, is feeling better and his energy has improved significantly. You assert that perhaps there was a virus, he was not sleeping well, or that the multivitamin helped his nutritional status. The patient thanks you for your help and returns home. However, you never discussed, nor did he voluntarily reveal, that he is Muslim and previously had been on a major fast as part of his religious beliefs. The weight loss is transient because of the fast, the decreased urination is also a result of the fast and he is a security guard at night so he could not easily partake in the late night meals that his wife served during this time of fasting which allows for meals after sundown. He did not feel comfortable sharing the information because of thoughts of suspicions, scolding and/or being told to alter his religious practice.

TABLE 4

Tips for the Health Care Provider

1. **Avoid generalizations based on race, gender, health insurance, job and/or economics.**
   Example: Do not assume that a 26-year-old AA female that comes in with 3 children and appearing slightly dishelved, is a single parent, on Medicaid with little education.
2. **Engender trust and be trustworthy.**
   Example: If you tell your patient that you will contact them within 3 days with lab results, make sure that you put this item on your calendar and do so or assign a staff member to make the call for you. This is especially important as you begin to establish your patient relationship with a new patient.
3. **Listen to the patient.**
   Example: Do look the patient in the eyes when he/she is talking, if you need to write notes, utilize a simple phrase like: "I am listening but need to take a few notes while you're talking so that I do not miss anything."
4. **Observe the patient's responses, posture and general appearance.**
   Example: A patient may begin to stare blankly during your discussion and when questioned simply answer "OK" or "yes" at inappropriate intervals. These may be clues that the patient is confused but is trying to appear as though they understand. Also look for increased fidgeting, shrugging of shoulders and other signs that the patient has been "lost."
5. **Never minimize or dismiss what the patient expresses as a concern.**
   Example: A 39-year-old AA male with hypertension comes into the office stating that the hypertensive medication that you have him on is not working for him, when questioned further he does not give you specifics as to the problem. Your nurse has checked his blood pressure, which is 130/82; previous BP was over 175/110. Do not simply say — you should be happy that your blood pressure is controlled. If the patient is experiencing side effects such as fatigue and/or erectile dysfunction — he may abruptly stop the medication but may not feel comfortable enough with you to discuss the specifics. Remember that the patient's concerns are the most important factor in compliance and treatment.
6. **Know the neighborhood and/or the general demographics of your patients.**
7. **Be open to alternative treatment options and keep abreast of the latest advances.**
   Example: A 71-year-old Asian male comes into your office with back pain, you prescribe a NSAID, along with ice packs. The patient's wife asks if she can take him to a naturopathic physician that will use acupuncture as a treatment modality. If you quickly dismiss acupuncture, you are not being culturally or medically sensitive as there are some studies that indicate a positive benefit. The better option is to encourage utilization of both modalities and follow up with the patient. If you are uncomfortable — contact the acupuncturist and discuss.
8. **Do not assume that because YOU are the same race or have the same ethnic background, that you are culturally competent.**
   There are several factors that affect one's culture, Race is just ONE.
9. **Do provide access to language interpreters, diverse patient education materials and an office décor that is inviting and display of diverse populations.**
   Check your office, are all of the pictures on the wall of one gender and/or race. Is there any diversity in your printed brochures or materials?
10. **Do provide cultural-competence training for physicians, health care providers and their staff.**

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Overview of the

National Medical Association

History and Mission

Established in 1895, the National Medical Association (NMA) is the oldest and largest African-American professional, educational, and scientific organization representing more than 25,000 African-American physicians and the patients they serve. NMA's mission is to function as the collective voice of African-American physicians and the leading force for parity in medicine; and a catalyst for the elimination of disparities in health. Through its membership, professional development, community health education, advocacy, research, and its efforts with federal and private agencies and corporations, the NMA is committed to improving the health status and outcomes of minority and disadvantaged people.

Membership and Constituents

Representing predominately African-American physicians, the NMA's membership comprises physicians in the primary care specialties, as well as all other medical and surgical subspecialties, academic medicine, and medical administration. NMA members, when compared to other physicians, serve a disproportionately high number of patients who are poor, uninsured, underinsured, beneficiaries of Medicaid or Medicare, African American and other minorities. Given the complexities in medicine and diverse ethnicities and culture, NMA physicians have traditionally served patients from every facet of the population and medical settings including academia, private, group and governmental practices.

Organizational Structure

The organizational structure of the NMA provides an established framework of collaborative linkages within which physicians as a principal group of health professionals can be mobilized to address major health issues and implement national health program initiatives. These physicians and the health institutions with which they are affiliated are a "natural" structure for addressing concerns that disproportionately or differentially impact African American and underserved populations. The NMA's membership represents over 42 diverse medical specialties and subspecialties. Headquartered in the District of Columbia, the NMA is governed by a 40-member Board of Directors and Specialty Section Chairs and has 35 state and 100 local affiliated medical societies.

The state and local societies are segmented into six geographic NMA regions, as follows:

Region I: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Puerto Rico, Rhode Island, Virgin Islands, and Vermont.

Region II: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia.

Region III: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

Region IV: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

Region V: Arkansas, Iowa, Kansas, Louisiana, Missouri, Nebraska, New Mexico, Oklahoma, and Texas.

Region VI: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

NMA has an established national network of affiliated community-based organizations and a powerful reach within African-American

communities and other communities across the nation, with a ratio of approximately one (1) NMA society for every 500,000 African Americans across the nation (based on 1997 U.S. Census data).

Educational Programming

NMA is focused on providing strong programs that are consistent with its mission and the ever-changing needs of NMA members and African-American patients. The Association's Annual Convention and Scientific Assembly are designed to provide educational experiences through special sessions, postgraduate courses, and individual specialty programs from 23 separate medical specialties. In-depth review of updated diagnostic methods and therapeutics are discussed in an effort to prepare participating physicians for current medical practice in their fields of specialty. Combined specialty sessions provide additional opportunities for discussion and debate. The objectives of the convention include each element of the association's programmatic objectives, including:

Professional Education

The NMA keeps its members abreast of advances across various medical specialties, as well as changes affecting medical practice. The Annual Convention and Scientific Assembly offers numerous professional educational opportunities. Additionally, the nationally recognized Journal of the National Medical Association (JNMA), established since 1906, which is the nation's leading source of written scientific exchange, particularly on minority populations.

Research and Scientific Exchange

The NMA advances scientific and clinical knowledge to identify and facilitate new directions in medicine. NMA's Annual Convention and Scientific Assembly is one of the nation's foremost forums on medical science and health and is the world's leading forum on African-American health issues. Throughout the regions and local societies of the NMA, there is continuous learning opportunities and exchange between members.

Patient Education

The NMA strives to decrease disparate health and promote healthy lifestyles, particularly among African Americans and other underserved groups. The scientific sessions conducted during the convention offer programs on patient education in health categories that excessively impact African Americans such as cancer, cardiovascular disease, HIV/AIDS, asthma, arthritis, and diabetes.

Health Policy

The NMA is a staunch advocate of the improvement of the health status and availability of quality health care of the world, particularly for African Americans. NMA utilizes multiple platforms to present results from expert consensus panels and develop policy statements on health issues that disproportionately affects minority communities.

Medical Work Force Diversity

The NMA works to increase the representation of African Americans and other minority groups in medicine. NMA is committed to increasing the African-American physician work force in the United States to reflect the growing diversity of our nation. Each year, the association hosts several scholarship benefits to raise funds for minority medical student scholarships and sponsors an annual competition for scientific exhibits. There are numerous specialty section competitions to promote scholarly exchange among medical students, interns, and residents. The NMA is also an avid supporter and collaborator with the Student National Medical Association.

The NMA is a dynamic organization that stands on a long and proud history of significant contributions to the nation's health. Further, the NMA continues to address the issues and concerns of all Americans and looks to the wealth of its membership and affiliates to make valuable contributions to the nation and the world's health. The NMA welcomes and invites physicians, other health care professionals, and organizations committed to our mission and without regard to race, gender, or nationality to join our efforts.